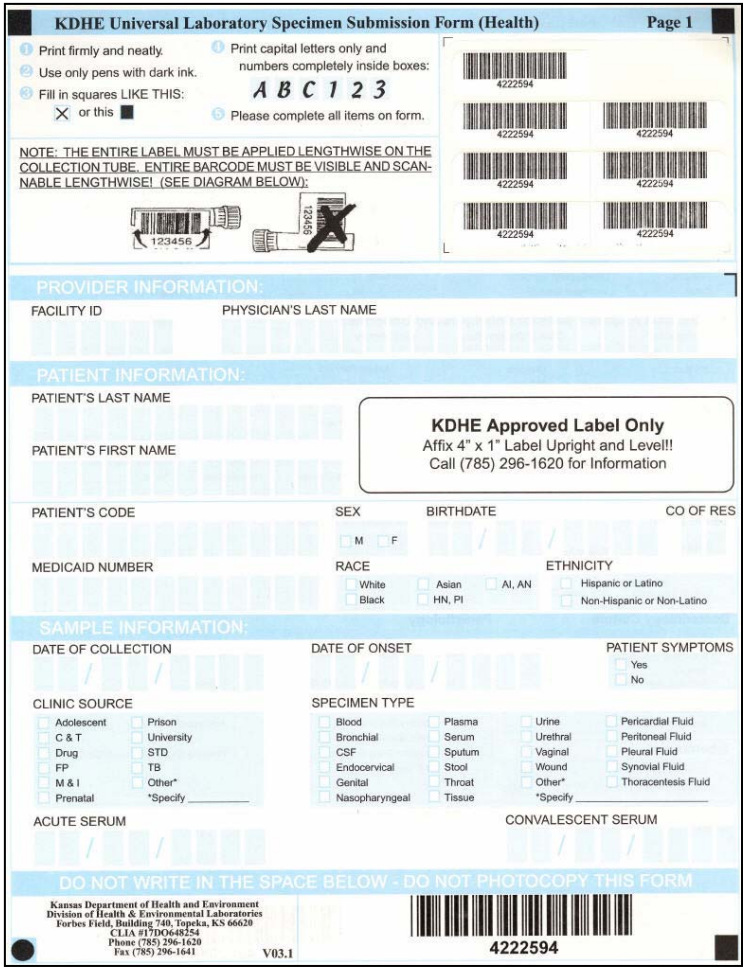
KDHE Division of Laboratories – Universal Laboratory Specimen Submission Form (Test Requisition) Pictorial Guide

Front Page



KDHE Universal Laboratory Specimen Submission Form (Health) Page 1

1 Print firmly and neatly.
2 Use only pens with dark ink.
3 Fill in squares LIKE THIS: ☒ or this ■
4 Print capital letters only and numbers completely inside boxes: A B C 1 2 3
5 Please complete all items on form.

NOTE: THE ENTIRE LABEL MUST BE APPLIED LENGTHWISE ON THE COLLECTION TUBE. ENTIRE BARCODE MUST BE VISIBLE AND SCANNABLE LENGTHWISE! (SEE DIAGRAM BELOW):

PROVIDER INFORMATION:
FACILITY ID
PHYSICIAN'S LAST NAME

PATIENT INFORMATION:
PATIENT'S LAST NAME
PATIENT'S FIRST NAME
PATIENT'S CODE
SEX M F
BIRTHDATE
CO OF RES
MEDICAID NUMBER
RACE White Black Asian HN, PI AI, AN
ETHNICITY Hispanic or Latino Non-Hispanic or Non-Latino

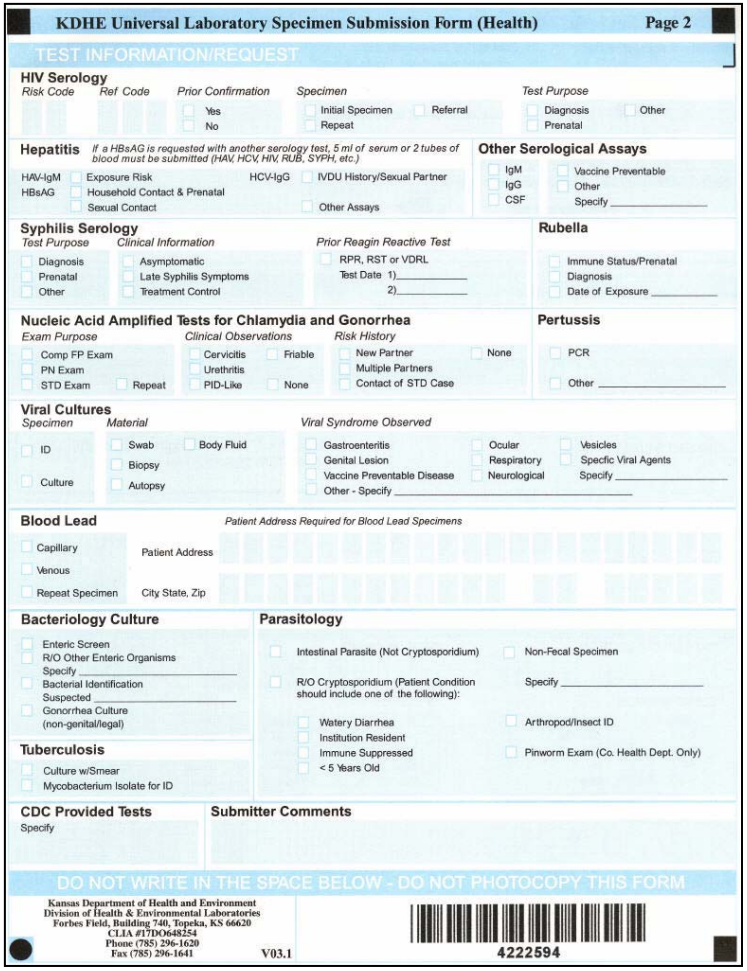
KDHE Approved Label Only
Affix 4" x 1" Label Upright and Level!!
Call (785) 296-1620 for Information

SAMPLE INFORMATION:
DATE OF COLLECTION
DATE OF ONSET
PATIENT SYMPTOMS Yes No
CLINIC SOURCE Adolescent, C & T, Drug, FP, M & I, Prenatal, Prison, University, STD, TB, Other* *Specify
SPECIMEN TYPE Blood, Bronchial, CSF, Endocervical, Genital, Nasopharyngeal, Plasma, Serum, Sputum, Stool, Throat, Tissue, Urine, Urethral, Vaginal, Wound, Other* *Specify, Pericardial Fluid, Peritoneal Fluid, Pleural Fluid, Synovial Fluid, Thoracentesis Fluid
ACUTE SERUM
CONVALESCENT SERUM

DO NOT WRITE IN THE SPACE BELOW - DO NOT PHOTOCOPY THIS FORM

Kansas Department of Health and Environment
Division of Health & Environmental Laboratories
Forbes Field, Building 740, Topeka, KS 66620
CLIA #17D0648254
Phone (785) 296-1620
Fax (785) 296-1641
V03.1
4222594

Back Page



KDHE Universal Laboratory Specimen Submission Form (Health) Page 2

TEST INFORMATION/REQUEST

HIV Serology
Risk Code | Ref Code | Prior Confirmation: Yes, No | Specimen: Initial Specimen, Repeat, Referral | Test Purpose: Diagnosis, Prenatal, Other

Hepatitis *If a HBsAG is requested with another serology test, 5 ml of serum or 2 tubes of blood must be submitted (HAV, HCV, HIV, RUB, SYPH, etc.)*
HAV-IgM, HBsAG: Exposure Risk, Household Contact & Prenatal, Sexual Contact
HCV-IgG: IVDU History/Sexual Partner, Other Assays

Other Serological Assays
IgM, IgG, CSF
Vaccine Preventable, Other, Specify

Syphilis Serology
Test Purpose: Diagnosis, Prenatal, Other
Clinical Information: Asymptomatic, Late Syphilis Symptoms, Treatment Control
Prior Reagin Reactive Test: RPR, RST or VDRL; Test Date 1) 2)

Rubella
Immune Status/Prenatal, Diagnosis, Date of Exposure

Nucleic Acid Amplified Tests for Chlamydia and Gonorrhea
Exam Purpose: Comp FP Exam, PN Exam, STD Exam, Repeat
Clinical Observations: Cervicitis, Urethritis, PID-Like, Friable, None
Risk History: New Partner, Multiple Partners, Contact of STD Case, None

Pertussis
PCR, Other

Viral Cultures
Specimen: ID, Culture
Material: Swab, Biopsy, Autopsy, Body Fluid
Viral Syndrome Observed: Gastroenteritis, Genital Lesion, Vaccine Preventable Disease, Other - Specify, Ocular, Respiratory, Neurological, Vesicles, Specfic Viral Agents, Specify

Blood Lead *Patient Address Required for Blood Lead Specimens*
Capillary, Venous, Repeat Specimen
Patient Address
City State, Zip

Bacteriology Culture
Enteric Screen
R/O Other Enteric Organisms Specify
Bacterial Identification Suspected
Gonorrhea Culture (non-genital/legal)

Parasitology
Intestinal Parasite (Not Cryptosporidium)
Non-Fecal Specimen Specify
R/O Cryptosporidium (Patient Condition should include one of the following): Watery Diarrhea, Institution Resident, Immune Suppressed, < 5 Years Old
Arthropod/Insect ID
Pinworm Exam (Co. Health Dept. Only)

Tuberculosis
Culture w/Smear
Mycobacterium Isolate for ID

CDC Provided Tests
Specify

Submitter Comments

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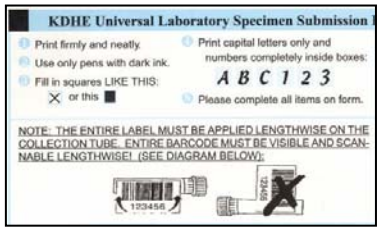
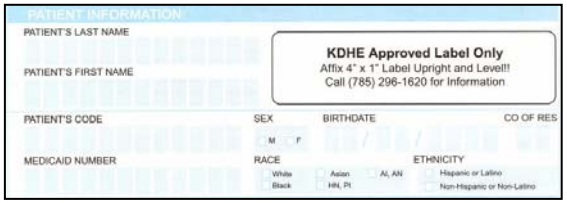


Carefully read and follow the instructions found on page 1 (front page), of the Universal Laboratory Specimen Submission Form (Universal Form).

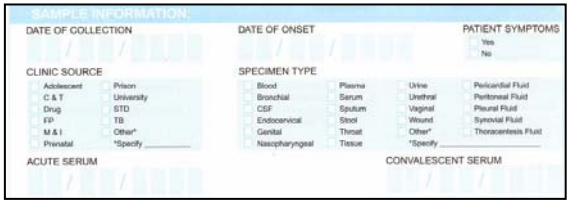
Place a Barcode Sticker on your specimen(s) primary receptacle and keep one sticker for your records.

Fill in your DHEL Facility ID number and requesting Physician's last name in the Provider Information Section.

The Facility ID number determines where patient results will be sent. The number must be entered correctly.



Fill in the Patient's last name, first name, code (code is optional and is for the patients use, not for DHEL), medicaid number, sex, DOB, county of residence, race, and ethnicity in the Patient Information Section.



Fill in the date of collection, date of onset, patient symptoms, clinic source, and specimen type in the Sample Information Section. If applicable, fill in the Date of Onset, Acute or Convalescent serum sections.

Select the required tests on page 2 (back page) of the Universal Form.

Note: If selecting blood lead, patient address must be filled in.

If you have additional comments important to your specimen, write them in the Submitter Comments Section.

- Each form number is unique and assigned to you. **DO NOT** photocopy the Universal Form.
- Mark all applicable areas completely.
- If you do not know your facility ID, call the Lab at: (785) 296-1620.
- Place completed submission form inside fibreboard shipper **outside of secondary container.**
- Universal Forms checked out by your facility may only be used by your facility. Please do not share with other facilities.